*NOTICE *
THIS APPLICATION WAS REVISED IN April 2019
– PLEASE READ CAREFULLY -

Change of Ownership License Application
To Operate an Ambulatory Surgical Treatment Facility

Regulations affecting the application for licensure of Ambulatory Surgical Centers can be found by clicking the Rules tab or link on the applications page.

The application should be submitted to this office at least 30 days prior to the change of ownership. In addition to the information requested within the application, the following must also be submitted:

1. A completed license application and $200 application fee. Application fees will not be refunded.

2. Articles of Incorporation, Articles of Organization, LLC Agreement, Articles of Incorporation, Partnership Agreement or Statement of Sole Proprietorship, under which the facility will operate. Corporations, Limited Partnerships and Limited Liability Companies must provide approved documentation from the Office of the Secretary of State to conduct business in the State of Alabama.

3. Approval from the State Health Planning and Development Agency.

4. A copy of the draft closing documents (such as a bill of sale, purchase agreement).

Upon successful review of the application, and building approval from Technical Services, a copy of the application will be forwarded to the Division of Health Care Facilities. A staff member from the unit will contact you regarding an on-site licensure visit to determine if the facility meets minimum requirements for a state license.

An on-site survey by the survey or regulatory staff may be required before the license can be granted.

*****NOTE***** Contact the department for ways to enhance the application to shorten the review time. The earliest date a license can be granted is the first day all documents and surveys have been approved by the department.

For state licensure purposes, a change of ownership is not effective until a new license certificate has been issued.

Please note: it is a violation of state law to provide ambulatory surgery center services before you are granted a license from this agency. If you have questions regarding your application, please call (334) 206-5175.

APPLICATION INSTRUCTIONS AMBULATORY SURGICAL TREATMENT FACILITY

Item 1, Applicant. The individual, partnership, corporation or other entity, who is the governing authority of the facility and to whom the license is granted **(not the facility name nor the individual completing the application, unless the applicant is an individual)**. The name entered in this section must be exactly as printed on the legal document establishing the entity. A copy of the legal document must accompany this application. Entities established in a state other than Alabama, must register to conduct business in Alabama with the Secretary of State's Office. A copy of the registration must also accompany this application. If the facility is leased, the lessee should be indicated as the applicant. The lessee may be an individual, partnership, corporation, or other entity. **NOTE - The applicant must be the operator of the facility, the entity that hires or fires the administrator, determines patient care issues, makes payment for facility obligations, etc.**

Item 6, Facility Name. The information provided on this line will be entered in the Provider Services Directory and the facility will be referred to by this name exactly as entered on this application. This name should be the same as on advertisements, facility letterhead, signs in front of the facility and certification information. This name must be unique; that is, it may not be the same as the name of any other licensed facility in Alabama, nor may it be so similar to the name of any other licensed facility that, in the judgment of ADPH staff, there could be any confusion to the public. Governing authorities operating more than one facility may give the facilities they operate similar, but not identical names. The name may be abbreviated if the abbreviation is also used on advertisements, facility letterhead, signs in front of the facility and certification information.

Item 8, Facility's Mailing Address. The facility mailing address, street address or post office box, must be within the same postal service area as the facility's physical location.

Item 14 b, Facility Information. Any specialty listed in this section must be consistent with the specialty stated on the Certificate of Need.

Item 17, Attestation of Responsible Person. A company officer, board member, administrator or other responsible person must sign the application and make the attestation.

Application Fee. The application fee for a hospital is $200 plus $5 for each bed, excluding the first ten beds. Application fees are not refundable. Make a check or money order payable to the Alabama Department of Public Health.

Attachments. Each attachment must be referenced as a specific applicable item. For example, attachment to item 12 d should be referenced in the document and labeled as such.

Printing of License Certificates

License certificates are now available on-line. When a license is granted or renewed the license certificate can be printed on-line at https://ph.state.al.us/FacilityCertificatePrint. A facility ID and pin number will be provided and must be used to print license certificates.

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 710, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

CHANGE OF OWNERSHIP APPLICATION TO OPERATE AN AMBULATORY SURGICAL TREATMENT FACILITY

1. _____
Applicant
(see instructions on page 2)

2. _____
Applicant Address

3. _____
City State Zip Code

4. _____
Applicant Telephone Number

5. _____
Facility Administrator

6. _____
Facility Name
(see instructions on page 2)

7. _____
Facility Physical Address

8. _____
Facility Mailing Address
(see instructions on page 2)

9. _____
City Zip Code County

10. _____
Facility Telephone Number

11. This application is to apply for (check one):

a. Change of Ownership ☐ b. Change of Ownership and name change ☐

The facility is currently licensed as _____.
(Facility Name)

APPLICATION FEE	**FOR DEPARTMENTAL USE ONLY**
APPLICATION FEES ARE NOT REFUNDABLE. **The fee is $200.**	Classification _____ Application Fee _____ Check # _____ Facility ID # _____

12. Applicant Information

a. Applicant is a (check one):

Individual	☐	Nonprofit Corporation	☐	City	☐
Partnership	☐	Hospital Authority	☐	County	☐
Corporation	☐	State	☐	Joint City County	☐
Limited Liability Company	☐	Other: _____ Specify			☐

b. List all the applicant's board members and officers (attach additional paper if necessary).

_____ _____

_____ _____

_____ _____

_____ _____

c. List the name(s) of any person or business entity that has 5% or more ownership interest in the applicant (attach additional paper if necessary). Also, attach a diagram depicting the organizational structure.

_____ _____

_____ _____

_____ _____

_____ _____

d. Does this applicant or any of its owners listed in item "c" operate any other health care facility in Alabama or in any other state? YES ☐ NO ☐ If yes, attach a list including the type(s) of facility(s), name(s), address(s), and owner(s).

e. Have any of the facilities listed in item "d" had any adverse licensure action taken against them or been subject to exclusion from the Medicare or Medicaid Reimbursement Programs? YES ☐ NO ☐ If yes, attach an explanation.

f. Has the applicant, officers or principals ever had a license application denied by this or any other state? YES ☐ NO ☐ If yes, attach an explanation.

13. Has the facility administrator listed in item “5" of this application:

    a. ever been convicted of a crime? YES ☐ NO ☐

    b. ever been found guilty of abusing another individual? YES ☐ NO ☐

    c. ever had adverse action taken against a professional license, for example, nursing home administrator license, attorney license, nurse license, physician license? YES ☐ NO ☐

    d. ever been excluded from participation in Medicare or Medicaid Reimbursement Program? YES ☐ NO ☐

    If yes to a, b, c, or d attach an explanation.

14. Facility Information

    a. This facility will have a maximum stay of (check one):

    ☐ 12 hours

    ☐ 23 hours

    b. This facility will operate as a (check one):

    ☐ general ambulatory surgical treatment facility.

    ☐ specialized ambulatory surgical treatment facility. The specialty is _____.

(see instructions on page 2)

    c. This facility will have _____ surgical units.

15. List the name and address of a hospital for which there is a formal working agreement for prompt referral and backup services for patients requiring attention for an emergency or other condition necessitating hospitalization **(attach copy of agreement to this application)**.

    _____

    _____

16. Provide the name, phone number, and email address for a knowledgeable person that can supply details about this application.

    Name (print) _____Address_____

    City, State, Zip _____

    Phone _____ Email _____

17. Attestation of Responsible Person:

I declare, under penalty of perjury, that I have personal knowledge about the statements made in this application and certify that all statements are true and correct. To the best of my knowledge, neither the applicant nor any of the principals, including myself, the owners, and the administrator, have operated or allowed to be operated this facility, or any other facility, without a license. I certify that I am authorized to make this representation on behalf of the applicant.

Signature: _____ Printed Name: _____

Title/Position: _____ Date:_____

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

_____
(Notary Public)

18. Administrator Signature:

I declare, under penalty of perjury, that I have not operated or allowed to be operated this facility, or any other facility, without a license. I agree to operate this facility according to the Rules of the Alabama State Board of Health.

_____ _____
Printed Name Signature

_____
Date

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

_____
(Notary Public)

MANDATORY ACKNOWLEDGMENT NOTICE

Pursuant to *Alabama Code* section 30-3-194, every applicant seeking from a state agency a license, certificate, permit, or authorization to engage in a profession, occupation, or commercial activity, must provide the social security number of the person signing the application, whether as an individual or on behalf of an entity or corporation. Failure to provide this social security number will result in the denial of the application.

Print or Type Name of Person Signing Application: _____

Social Security Number of Person Signing Application: _____

Print or Type the Facility Name: _____

THIS PAGE **NOT** FOR PUBLIC RECORD